Internal Medicine
Residency Training Program

Policies and Procedures Manual
2011-2012

Effective July 1, 2011

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I. DEFINITIONS AND DESCRIPTIONS

Resident: The term "Resident" encompasses all Internal Medicine and Internal Medicine Pediatrics Program Residents from PGY1 to PGY 4.

Intern: The term "Intern" refers to trainees who are going into or are currently in their first year of training as a PGY1.

Upper Level: The term "Upper Level" refers to trainees in their second year of training to their 3rd year for Categoricals and 4th year for Internal Medicine Pediatrics Residents.

Program: The term "Program" refers to the Internal Medicine Residency training program.

Sponsoring Institution: The term Sponsoring Institution refers to the University of Texas Medical School at Houston.

UT Health: The term UT Health is an alternative name for the University of Texas Medical School at Houston.

II. PROGRAM OVERVIEW

The mission of the University of Texas Houston Internal Medicine Program is to prepare each Resident for a successful career as a Physician. We strive to provide an excellent foundation for each Resident so that no matter which career path is chosen, he/she will have the ability to excel. Training encompasses development of a high level of clinical skills, as well as a strong fund of knowledge of the pathophysiology, manifestations, and principles of treatment of diseases generally seen by internists. Internal Medicine is a discipline encompassing the study of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness. Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.

One of the fundamental principles of Internal Medicine training is the progressively increasing degree of responsibility that Residents are given for the care of patients. The principles of patient care demand that the attending physician retain ultimate responsibility for the welfare of his or her patients, however, this rule allows delegation of authority to the Residents for management of patients on a day to day basis. Attending physicians will delegate progressively more and more authority to the house officer as he or she progresses through the training program. Acceptance of this responsibility requires that the Housestaff have time to assess the patient, to develop a reasonable formulation of the patient's problems, and to propose a plan of management. With the concurrence of the attending physician, the plan of management may then be undertaken by the Resident. Additionally, the attending physician has an obligation to teach general and/or subspecialty internal medicine to the Residents. This teaching is best carried out in the context of the immediate clinical situation. The attending physician and Residents should work together for the benefit of the patient.

Throughout their training, the Residents are exposed to several different kinds of clinical experiences. At Memorial Hermann Hospital, M.D. Anderson Cancer Center and Lyndon B. Johnson General Hospital, there are inpatient services staffed by full time faculty. At Memorial Hermann and St. Luke's Episcopal hospitals, there are also patients under the care of voluntary faculties of the University of Texas Medical School and Baylor College of Medicine respectively. There are rotations through general and subspecialty inpatient services and outpatient clinics, medical intensive care, coronary care units and emergency rooms. All categorical Housestaff attend a weekly continuity clinic.

The first year resident serves as an intern on inpatient services, outpatient clinics, emergency departments and critical care units. The upper level schedule consists of a combination of inpatient services and critical care units, emergency departments, outpatient clinics, and subspecialty consultation services. The consultation services allow the resident to develop in-depth knowledge about specific areas of internal medicine and permit close personal interactions with members of the faculty. Furthermore, residents can participate in some specialized technical procedures during their subspecialty rotations. There is also the opportunity to rotate through general internal medicine consultations, during which the resident acts as a consultant to other departments.

In scheduling rotations, we consider four factors. First and most important is educational value. Over the three years, the resident should rotate through most or all of the major medical subspecialties. The second is the requirement of the American Board of Internal Medicine that there be at least twenty-four months of "meaningful patient responsibility" in the three year residency. The third factor is the requirement for staffing of our inpatient and subspecialty consultation services. The fourth is the preference of the resident for particular subspecialties. We try to arrange for each resident a reasonable mixture of the various experiences available in this training program.

A. PROGRAM LEADERSHIP

Our faculty strives to be distinguished for its scientific, clinical and teaching excellence in all major disciplines within the broad field of internal medicine. Attainment of this goal requires the operation of an excellent Resident training program. Therefore, the residency program is of the highest departmental priority. All physicians on the faculty are expected to teach and make contributions to the Residency training program.

1. Chair

Dr. David D. McPherson is Chairman, Department of Internal Medicine, Professor and Director of the Division of Cardiology, Executive Director – Center for Clinical and Translational Sciences, he is the holder of the James T. and Nancy B. Willerson Chair, and Medical Director of the Heart and Vascular Institute at the University of Texas Health Science Center at Houston.

In 2006 he was recruited to the University of Texas Health Science Center at Houston to head the Division of Cardiology. He was appointed the Willerson Chair of Internal Medicine in 2008 with a mandate to direct, lead, and expand the Department into a new decade of Academic Achievement.

2. Vice Chair

Dr. Carmel Bitondo Dyer is Vice Chair of Medicine, professor and director of the geriatric medicine division at the University of Texas Medical School at Houston, and the Roy M. and Phyllis Gough Huffington Chair in Gerontology. She is a 1988 graduate of Baylor College of Medicine, where she completed her Internal Medicine residency and Geriatrics Fellowship. She founded the geriatrics program at the Harris County Hospital District and the Texas Elder Abuse and Mistreatment Institute. Her research and publications have been in the area of elder mistreatment. She was a delegate to the 2005 White House Conference on Aging and has addressed the U.S. Senate. She has received national and local recognition for her teaching abilities and her dedication to the health care of older persons.

3. Program Director

The ultimate responsibility for administration of the training program rests with the Vice Chair of Medicine for Education and GMEC approved Program Director for Internal Medicine, Dr. Philip Orlander. Prior to beginning his tenure with the Residency Program, Dr. Orlander was the Program Director for the Endocrinology, Diabetes and Metabolism fellowship beginning in January 1991. He has been instrumental in the education of the Internal Medicine Residents since his appointment as Assistant Professor with the University of Texas Medical School at Houston in 1983. Dr. Orlander is certified in both Internal Medicine (1979) and Endocrinology, Diabetes and Metabolism (1981) and maintains current certification in both areas. He is currently licensed in both Texas and Arizona with Medical Staff appointments at the University of Texas Medical School at Houston.

Dr. Orlander received his undergraduate degree from New York University and was awarded his medical degree from the Free University of Brussels, Belgium. He completed his internship and residency training in Internal Medicine at St. Raphael's Hospital, New Haven, CT. His Endocrinology fellowship training was at St. Raphael's Hospital, New Haven, CT, and at the University of Arizona, Tucson, AZ. He is board certified in Internal Medicine, and Endocrinology and Metabolism. In 1983, he joined the faculty at the University of Texas Medical School at Houston as an Assistant Professor, and subsequently was promoted to Associate Professor in 1991, Professor in 1997, and Division Director of Endocrinology, Diabetes, and Metabolism in 1993. In 2004, he became Vice-Chairman of Internal Medicine for Education and was named Interim Chairman of the Department of Internal Medicine in May, 2007.

Dr. Orlander has had a strong interest in Medical Education, both at the undergraduate and postgraduate level. He was course director for Physical Diagnosis from 1991 to 2004, Chairman of the Curriculum Committee from 1993 to 1998, from 2002-2007, and was named Assistant Dean for Curricular Affairs in 2005. On the post-graduate level, he has been Program Director for the Endocrinology, Diabetes, and Fellowship program since 1991, and Vice-Chairman for Education since 2005. He is a member of Alpha Omega Alpha and was elected to the University of Texas Academy of Health Science Education in 2006. He is the recipient of the Herbert L. and Margaret W. Dupont Master Clinical Teaching Award, the Award for Humanism in Medicine, and multiple Dean's Excellence in Teaching Awards.

Responsibilities of the Program Director

The Program Director administers and maintains an educational environment conducive to educating the Housestaff in each of the ACGME competencies: Patient Care, Medical Knowledge, Practice Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and System-Based Practice. The Program Director initiates and monitors the didactic and clinical education at all participating sites and, continually evaluating the effectiveness of the teaching/learning environment. As approved by the Program Director, the local director at each participating site is accountable for Residency Education and is evaluated regularly to ensure that the best education quality is achieved at each site. The Program Director is also responsible for approving faculty for teaching of Housestaff. Faculty is reviewed annually and given a summary review of their performance for the preceding year based on the confidential and anonymous resident evaluations and comments.

4. Associate Program Directors

The Program Director is aided in the administrative and clinical oversight of the educational program by 5 Associate Program Directors as follows:

	Emily Barker, MD	Senior Associate Program Director Assistant Professor of Medicine Division of General Internal Medicine
	Andrew Ho, MD	Associate Program Director Assistant Professor of Medicine Division of General Internal Medicine
	Brett Stephens, MD	Associate Program Director Program Site Director, LBJ Hospital Assistant Professor of Medicine Division of Renal Diseases and Hypertension
	David Wolf, MD	Associate Program Director Assistant Professor of Medicine Division of Gastroenterology, Hepatology and Nutrition
	Robby Wesley, DO	Associate Program Director Assistant Professor of Medicine Division of General Medicine

Each Associate Program Director is a clinician with broad knowledge of, experience with and commitment to Internal Medicine as a discipline, patient centered care, and to the generalist training of residents, and hold current certification from the American Board of Internal Medicine in Internal Medicine and if applicable, his/her respective subspecialty. Each Associate Program Director reports directly to the Program Director. Each will commit an average of 20 hours per week to the administrative and educational aspects of the educational program.

5. Core Faculty

The residents in the Internal Medicine Residency enjoy the expertise of 9 institutionally based core faculty members, one faculty for each Internal Medicine subspecialty, who not only serve as core faculty, but also as the subspecialty education coordinators. These faculty are expert competency evaluators who work closely with the program director and associate Program Directors in development and implementation of the evaluation system and in teaching and advising the Housestaff. Each core faculty is ABIM certified in Internal Medicine and, if applicable, his/her respective subspecialty, and are clinically active in both direct patient care and observation of residents in their patient care. Each core faculty member is accountable to the Program Director for coordination of the residents' subspecialty educational experiences in order to accomplish the goals and objectives in the subspecialty. The core faculty also participate in the Internal Medicine mentorship program available to interns to help guide and advise interns, and Houestaff as a whole, about career and educational goals.

Sandeep Agarwal, MD
Division of Rheumatology

Eugene Boisaubin, MD
Division of General Medicine

Anu Davis, MD
Division of Endocrinology

Maxine De La Cruz, MD
Division of Geriatrics

Ali Denktas, MD
Division of Cardiology

Rodrigo Hasbun, MD
Division of Infectious Disease

Anneliese Gonzalez, MD
Division of Oncology

Brandy McKelvy
Division of Pulmonary and Critical Care

Amber Podoll, MD
Division of Renal Disease and Hypertension

6. Program Staff

The main Housestaff office is located in the Medical School Building, MSB 1.134 and houses the clerical staff responsible for the operation of the program.

Charity Sembera
Coordinator II, Internal Medicine Residency Program
UT Houston Medical School, MSB 1.134

Residency Program Office Contact Information

University of Texas Medical School at Houston
Department of Internal Medicine
6431 Fannin, Suite 1.134
Houston, TX 77030

Phone Number: 713-500-6525
Fax Number: 713-500-6530
Email: residency.imed@uth.tmc.edu

B. SPONSORING INSTITUTION

The Internal Medicine Residency Program is sponsored by UT Health and established under the department of Internal Medicine. The Sponsoring Institution provides technical and professional personnel as requested by Housestaff and as delegated by the University of Texas Medical School at Houston's Handbook of Operating Procedures.

The mission of The University of Texas Medical School at Houston is to provide the highest quality of education and training of future physicians for the State of Texas, in harmony with the State's diverse population, and to conduct the highest caliber of research in the biomedical and health sciences. The institution aims to provide an educational environment stressing primary care and quality care, and to prepare advanced Residents to serve all patients in need, whatever their means, to make contributions to the understanding, prevention and treatment of disease and injury, and to pursue a lifetime of study so that they will remain the best possible practitioners of medicine. The fulfillment of the academic mission requires the provision of exemplary clinical services, primacy of prevention, leadership in research and research training, and continuing education of graduates and other healthcare providers.

The University of Texas Medical School at Houston is part of The University of Texas Health Science Center at Houston, a comprehensive health science center located in the world-renowned Texas Medical Center. The institution, on behalf of its administration and faculty, assumes ultimate educational responsibility for all of the graduate medical education programs under its sponsorship. To that end, the institution is committed to excellence in both education and patient care and will provide an ethical and scholarly environment for these activities. Through the Associate Dean for Educational Programs in collaboration with the Graduate Medical Education Committee, the institution will ensure substantial compliance with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements and enable the ACGME accredited-programs to achieve substantial compliance with the Institutional, Common and specialty-specific Program Requirements and the ACGME Policies and Procedures. In order to provide effective educational experiences for residents that lead to measurable achievement of educational outcomes, the institution will provide appropriate clinical venues for resident education through agreements with approved patient care facilities. Therein, the institution will provide guidance and supervision of residents while facilitating their professional, ethical and personal development and will further ensure that the patient care provided by residents is safe and appropriate. The institution is committed to providing the necessary educational, financial and human resources necessary to support graduate medical education.

C. AFFILIATED INSTITUTIONS

1. Hospitals

The Residents in the Internal Medicine Residency Program enjoy access to facilities located in the world renowned Texas Medical Center. Specifically, hospitals affiliated with UT Health for the purpose of the Internal Medicine Residency Training Program includes:

a. Memorial Hermann Hospital-TMC
b. Memorial Hermann-TIRR
c. Lyndon B. Johnson General Hospital (Harris County Hospital District)
d. The University of Texas M.D. Anderson Cancer Center
e. St. Luke's Episcopal Hospital
f. The Mainland Allergy and Immunology Clinic

2. Clinics

Clinics/Ambulatory Settings affiliated with UT Health for the purpose of the Residency Training Programs include:

a. University of Texas Professional Building (UT Physicians)
b. UTHSC-H Center (West Loop Clinic)
c. Thomas Street Clinic (Harris County Hospital District)
d. Quentin Mease (Harris County Hospital District)
e. Lyndon B Johnson Hospital Clinic (Harris County Hospital District)

D. LEVELS OF TRAINING

Progressive levels of training in the Program are designated as Post Graduate Year ("PGY") 1 through 3 for Categorical Residents. After the initial PGY-1 appointment term, the PGY level to which a Resident is appointed will be determined by the Program Director, in consultation with the Department Chair and other faculty, based on the Resident's level of education, experience, and demonstrated ability, clinical performance, and professionalism.

E. APPOINTMENT AND REAPPOINTMENT

1. Appointment

Applicants to the Internal Medicine Program must meet one of the following criteria to be eligible for appointment to the Program:

- Graduates of United States or Canadian medical schools accredited by the Liaison Committee on Medical Education (LCME).
- Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
- Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
  - (a) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment, or,
  - (b) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.
- Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME accredited medical school.

Generally, a Notice of (Re-) Appointment will be issued to an "on-cycle" Resident no earlier than four months prior to the Resident's proposed start date. The appointment will generally extend for a period encompassing the PGY year, (typically 12 months); Residents may be appointed for shorter time periods at the discretion of the Program Director.

Residents may not have concurrent agreements, appointments, and/or contracts with other hospitals or institutions while under appointment to the Program. To be fully effective, the Notice of Appointment is signed by the Resident and an authorized representative of the Medical School on behalf of the Foundation.

** Only J-1 Visas are issued.

2. Reappointment and Promotion

Promotion to the next level of training and/or reappointment is made annually at the discretion of the Program Director. The decision to promote and/or reappoint a Resident (hereinafter "Resident") will be based on performance evaluations and an assessment of the Resident's readiness to advance (including, but not limited to attainment of the ACGME Competencies at the respective level of education, experience, demonstrated ability, clinical performance, and professionalism).

In order to receive credit for a month, the Resident must actively participate in at least two (2) weeks of the month. In addition, credit will only be given to those Residents who successfully pass the rotation. Unsatisfactory or non-passing scores are a 3 and below on any competency and/or comments indicating that the performance needs attention. Any rotations where a resident received an overall rating of "Unsatisfactory" will need to be repeated. An intern who, in the opinion of the Program Director and Chairman or other pertinent faculty are not prepared for the responsibilities of an upper level resident, *may* be offered the opportunity to extend his or her internship up to one year. Interns who fail to successfully complete the repeat of a PGY-1 year will not have their contract renewed.

In instances where a Resident will not be promoted and/or reappointed, the Program Director will provide the Resident with a written notice of intent not to promote and/or not to reappoint no later than four months prior to the end of the Resident's current appointment term. However, if the primary reason(s) for the nonpromotion and/or non-reappointment occur(s) within the four-month period preceding the end of appointment term, the Program Director will provide the Resident with as much written notice of the intent not to promote and/or reappoint as circumstances will reasonably allow.

F. STRUCTURE OF THE PROGRAM

The Internal Medicine Residency Program values education of our Residents above all. The policies of the Program are formulated with this in mind. Educational experiences of the program include interactions with residents, fellows and attending physicians, as well as other members of disciplinary teams including Nurses, Physician Assistants and administrative personnel.

The Internal Medicine Residency Program consists of 36 months of Graduate Medical Education. There are at least 32 rotations available for Residents in the Program and each resident can expect an experience in the following rotations:

Intensive Care Unit MHH/LBJ *
Ambulatory MHH/LBJ
General Medicine Wards MHH/LBJ
Emergency Room LBJ
Coronary Care Unit MHH
Renal Wards MHH/LBJ
Gastroenterology Wards MHH/LBJ
Hepatology Wards MHH/LBJ
Oncology Consults LBJ

Cardiology Consults MHH/LBJ (Upper Level)
Endocrinology Consults MHH/LBJ (Upper Level)
Geriatrics MHH/LBJ (Upper Level)
Gastroenterology Consults MHH/LBJ (Upper Level)
Hematology Consults MHH/LBJ (Upper Level)
Infectious Diseases Consult MHH/LBJ (Upper Level)
Pulmonary Consults MHH/LBJ (Upper Level)
Renal Consults MHH/LBJ (Upper Level)
Rheumatology Consults MHH/LBJ (Upper Level)

Each graduating Resident that successfully completes the program will be competent and qualified to sit for the Internal Medicine Certification exam

* Intensive Care Unit :Total required emergency medicine experience will not exceed 3 months in a 3-year residency. Total Required critical care experience will not exceed 6 months in a 3-year residency. If a resident requests critical care electives, the total experience may not exceed 8 months.

G. SCHEDULES

1. Monthly Schedules

Each Residents schedule is formulated so that by the end of training, the Resident will have completed 36 calendar months (including vacation time) of accredited graduate medical education and will be eligible to sit for the Boards upon completion of the program. The educational efforts of faculty and residents are designed to enhance the quality of patient care, and the education of the residents. At least 1/3 of the residency training occurs in the ambulatory setting and at least 2/3 occurs in the inpatient setting.

Beginning June 24 of each academic year, Resident's schedules are posted on AMION for the full academic year (http://www.amion.com; password uthim) and updated as needed. Changes should be made three weeks after the initial schedule is released. Three weeks after the Residents are notified of the posting of the initial schedule, each Resident shall review his/her individual schedule and make any necessary changes with the appropriate scheduling chief. After the three weeks for schedule changes has passed, there will be no changes made upon request unless there is an emergency or adjustments are required based on the needs of the scheduling chief. Should there be a valid emergency, the request must be made *in writing* to the scheduling chief and Program Director. All changes are reviewed by the Assistant Chiefs of Service and the Program Director because of the needs for staffing of services, and the requirements of the American Board of Internal Medicine and the ACGME.

2. Vacations and Time Off

Residents classified as PGY-1 are permitted the equivalent of two (2) calendar weeks of vacation each 12 month appointment term. Vacation leave is pro-rated for appointment terms of less than twelve months. Residents classified as PGY-2 and above are permitted the equivalent of three (3) calendar weeks of vacation each year. In addition to these allotted days the Program allows each Resident 4 days off around their choice of Holiday. The 4 days off are given on a first come, first serve basis.

Resident's must coordinate vacation scheduling with the Internal Medicine Residency Program, as well as with the Assistant Chief of Service in charge of scheduling to ensure adequate coverage of services. No more than two (2) consecutive week's of vacation may be taken without permission from the Program Director. The vacation schedule is incorporated into the yearly master schedule. Resident's are not eligible to accumulate annual vacation and unused vacation does not roll over from one academic year to the next. Resident's leaving the Program will not be compensated for unused vacation nor Residents are provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period. It is the obligation of the Resident who is off to coordinate with his/her team members to ensure that days off are staggered and not more than one intern is away at a time. Patients of a resident who are off should be covered by other residents on the team.

Requests for a change in vacation schedule should be turned in to the appropriate scheduling chief before the beginning of the academic year. Any request for a change in requested vacation time is subject to the approval of the appropriate scheduling chief and the Program Director or the Program Directors designee.

Residents are not allotted extra time off for completion of USMLE Step exams or interviews for fellowship opportunities, attending classes, or other elective endeavors. For situations where outside obligations interfere with your ability to complete your required work within the program, Residents must ask for vacation in advance or arrange their own coverage and notify the appropriate scheduling chief and the Program Director or the Program Directors designee. If no coverage is found by the resident, they must report to their assigned duties that day. It is a breach of professionalism not to show up to yur required rotation without notifying all of the appropriate personnel including but not limited to the scheduling chief and the Program Director or the Program Directors designee. Each resident is responsible for discussing the policy of time-off with his/her attending at the beginning of the month to ensure that the attending policy's with regards to time off are also met.

3. Ready Reserve/Jeopardy Call

The Ready Reserve is backup call for emergency situations only. This is not considered "at-home call." Every day there are 2 Upper Levels and 2 Interns that on on an ambulatory or consult service for the month. If a Resident has an emergency situation where he/she cannot take call we pull someone from the Ready Reserve pull to work. The Chief Resident must be informed by paging them at 22001 and must be called as soon as you know you will not make it to work, to get somebody pulled. No other mode of communication is acceptable other than telephone conversation. If you do not inform the chief residents appropriately, then you will be expected to show up for your rotation until coverage is found for you. In addition, any absences for more than 24 hours will require a physician visit and note (this can be your PCP, the ER or the student health center).

4. Sick Leave/Leave of Absence

Paid sick leave accrues at a rate of one (1) day (eight (8) hours) each month and may accumulates to a maximum of thirty (30) days. Paid sick leave carries forward from year to year; however, unused sick leave remaining as of the date of separation from the Program is forfeited without compensation.

Residents are not eligible for UT Health "sick leave pool" leave. The program is responsible for tracking Residents' sick leave through the GMEIS system. All requests for sick leave must be approved by the appropriate scheduling chief, Program Director/Program Director's designee, and reported to the appropriate Residency Coordinator.

5. Leave of Absence

In the event an illness exceeds accumulated paid sick leave and vacation time, a leave of absence without pay may be granted by the Program Director.

All requests for **Leave of Absence** must be approved in advance by the Program Director in accordance with applicable state and federal laws and accreditation requirements. An extended LOA, which exceeds the twelve (12) week allotment, **may** necessitate resignation from the Program. The Resident may seek reappointment to the Program at a later date.

LOA may be comprised of paid leave (including both paid sick leave and vacation) and/or leave without pay (LWOP). When LOA is requested for a medical reason (including

pregnancy), the eligible Resident must exhaust all accumulated paid sick leave and accumulated vacation prior to beginning any LWOP.

6. Military Leave

A Resident who voluntarily enlists in one of the branches of the armed forces and is called to serve, or who is a member of one of the reserve branches of the armed forces, Texas National Guard, or the commissioned corps of the Public Health Service, or a Resident who voluntarily or involuntarily leaves his or her employment position to undertake certain types of service in the National Disaster Medical System, who is called to active duty by the President of the United States during an emergency, or who is called for annual tours of duty, will be entitled to no more than 15 days paid military leave during the Resident's appointment period. Residents must notify their Program Director as soon as they become aware of their military orders and provide the Program Director with a copy of such orders. Military leave over 15days shall be considered unpaid leave. On completion of military duty, the Resident must report back to his or her regular program.

7. Family and Medical Leave (FMLA)

Consistent with the Federal Family and Medical Leave Act of 1993 (FMLA), the University of Texas System – Medical Foundation will grant up to 12 calendar weeks of leave in a 12-month period to residents. Family and medical leave may be granted for one or more of the following reasons:

- Birth of son/daughter and care after such birth;
- Placement of son/daughter for adoption or foster care;
- Serious health condition of spouse, child, or parent of resident; or
- Serious health condition of resident (unable to perform the functions of his or her position)

The duration of LOA must be consistent with satisfactory completion of training (credit toward specialty board qualification), which will be determined by each department in consultation with the GME office.

A Resident may continue his/her personal insurance coverage and dependent insurance coverage's during a period of LOA at his/her own personal expense. Arrangements for these premium payments must be made prior to the commencement of the leave. The program is responsible for payment of the resident's portion of the premium when the LOA qualifies under the Family Medical Leave Act.

The Internal Medicine Resident taking FMLA will be paid for an appropriate amount of leave time, beginning with sick leave and any remaining vacation. After these accumulations have been exhausted, the resident will be put on Leave of Absence (LOA). Once the resident has been put on LOA he/she will not receive his/her monthly stipend. The department will pay for benefits only when all sick leave and vacation has been exhausted.

The first four (4) weeks of leave are consistent with the ABIM policy and therefore no make up rotations are required. The ABIM allows up to 3 months leave for vacation time, parental leave, or illness in a 36 month training period. Residents may take up to one month per year of training. Training must be extended to make up any absences exceeding the one month per year of training.

The Program tries to maintain a flexible and reasonable policy concerning maternity leave. As rearrangement of schedules will likely be necessary, you must notify the program director, as well as one of the residency coordinators, as soon as you know that you may have a situation that will require FMLA and or greater than 2 weeks of time off.

8. Holidays

Residents are not subject to the UT Health holiday schedule. Any holidays taken are at the discretion of the Program Director based on staffing needs for full coverage of services that will be operating during any "holiday" period. Time off must be approved in advance.

All residents get an additional 4 day vacation around the holiday of choice, depending on the schedule and need for coverage. During this time, while the Resident is on holiday, the remainder of the Residents will cover the ward and emergency services. There will be no other Holidays allotted to the Resident besides the one chosen.

H. SUPERVISION POLICY

Degrees of supervision are utilized by the Program as follows to ensure that limited autonomy and decision making is available as the Resident graduates through the levels of education.

Direct Supervision – the supervising physician is physically present with the resident and patient.

Indirect Supervision

- with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

1. General

The ultimate responsibility for the supervision of the Residents within the Program rests with the Program Director. He/she monitors resident supervision at all participating sites. The Program Director, in conjunction with the Associate Program Directors, elects qualified faculty to provide appropriate Direct Supervision of residents and interns in patient care activities. At the beginning of each rotation, the Housestaff will be introduced to his/her attending who will be an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care and for the Direct Supervision of the resident and intern. Each site and rotation has adequate faculty to instruct and supervise all the residents assigned to the rotation and location. The number of learners on each service will be limited to 8 so that attendings have adequate time to effectively teach the Housestaff. Residents are provided with rapid reliable systems for

communication with supervision faculty. Faculty scheduled to supervise on a rotation are required to provide residents with continuous supervision and consultation.

Over the course of the 36 months of residency, each resident must demonstrate proficiency in each of the critical clinical skills to be allowed increasing responsibility in patient care, leadership, teaching, and administration. These skills include, but are not limited to, using appropriate interview and examination techniques, documenting the encounter in a timely manner, ordering invasive diagnostic and therapeutic studies, ordering high risk medications, and performing common procedures. All residents must demonstrate proficiency in a simulated environment prior to attempting supervised procedures. Residents must then be certified by the attending after Direct Supervision of the procedure prior to performing or supervising the procedure. An electronic log will be kept of all procedures and signed off by the appropriate individual in the University's GMEIS system. Unless otherwise specified, promotion to a PGY-2 or PGY-3 year will carry with it the ability of performing or supervising certain procedures as specified at each clinical site. Regardless of the site or time of day, an attending physician must Indirectly Supervise procedures by being physically present at the site to be able to help if Direct Supervision is necessary with procedures. The academic hospitalist will serve this purpose at times that the designated attending is not on site. For all other medical decision making, an attending physician must be easily available by phone at all times. When on a rotation where a fellow is present, the Resident and Intern will also be directly supervised by him/her in procedures and patient care matters only after the attending has certified that the Resident is competent to perform and supervise the procedure. Residents and faculty members are responsible for informing patients of their respective roles in each patient's care.

Overall delegation of progressive authority is assigned by the Program Director. The Program director has entrusted the authority to determine appropriate authority within a rotation to the attending faculty on service, directly supervising the resident and intern's patient care interactions. Attendings are allowed to delegate portions of care to Residents based on the needs of the patient and the skills of the resident, however, all medical decisions are reviewed by the attending physician. The progressive authority that necessarily comes with advancement in PG year is determined solely by the Program Director after review of evaluations and comments based on the 6 ACGME core competencies.

There are certain circumstances and events in which residents must communicate with the appropriate supervising faculty members. Those circumstances include, but are not limited to a significant change in the patient's status, a need for a high risk procedure or treatment, a concern on a treatment decision, and any act that may impact patient safety. Housestaff should use their judgment on any other issues that arise, however if there is any question about the seriousness of a circumstance, it should <u>always</u> be addressed with the attending.

2. Inpatient Services

The inpatient services are organized so as to provide high-quality medical care, allowing the house staff limited autonomy for independent decision-making while allowing the attending the opportunity to directly and indirectly supervise the residents, ensuring appropriate patient care.

General Medicine Ward Team (MHH;LBJ)

Each Ward team consists of one (1) or two (2) upper level Resident(s), two (2) interns, and three students. In this setting the intern has Direct Supervision in patient care and

procedures from the attending physician and upper level resident during the day. At night, the intern is indirectly supervised by the attending, with direct supervision immediately available via telephonic or electronic modalities as well as the academic hospitalist, who will serve as Indirect Supervision. The upper level resident is responsible for seeing every patient on the day of admission and writing an upper level note. He/she is responsible for reviewing and approving diagnostic and treatment plans with the interns and students every day prior to Attending Rounds with oversight by the attending. The upper level will review patient's progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning with oversight from the attending. The upper level is also responsible for supervising procedures by the interns as well as creating an atmosphere where the interns and students are encouraged to ask for help when appropriate. An attending is always physically on site to help with procedures if and when necessary. The academic hospitalist may serve this purpose when the designated attending is not on site.

The upper level Resident on General Medicine Wards is directly supervised by the attending physician assigned to his/her team during the day and indirectly supervised by the attending, with direct supervision immediately available via telephonic or electronic modalities. The academic hospitalist is also available onsite for Indirect Supervision of the upper level resident, and is immediately available to provide direct supervision if necessary. Patient based teaching must include direct observation or indirect consultation between resident and attending including bedside teaching, discussion of pathophysiology and teaching rounds. Attendings will be available to oversee procedures and medical decision making of the Residents.

Coronary Care Unit (CCU MHH)

Each CCU team consists of 4 residents and 4 interns and 1 Cardiology fellow. Each Resident is paired with one intern comprising a subteam. In this setting interns have Direct Supervision and education from the attending physician and upper level resident. The primary role of the PGY-2 and 3 residents are to directly supervise and educate the interns and students. The resident will be responsible for initial evaluation of all patients, including assimilation of old records and outside information, seeing every patient on the day of admission with the intern and dividing the admissions equitably, commensurate with experience level. The upper level resident will review and approve diagnostic and treatment plans with the intern every day prior to Attending Rounds, review patients' progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning. The Resident is responsible for creating an atmosphere such that the intern is encouraged to ask for help when appropriate. The Resident will directly supervise procedures done by interns. As the intern progresses further into his/her training and when appropriate, the resident should allow the Intern limited autonomy through indirect supervision and ultimately observation when the intern is prepared to move to a team lead position, being always physically located at the sight for Direct Supervision or Oversight.

The upper level Resident on the CCU is directly supervised by the attending physician assigned to his/her team. With the progressive responsibility given to upper levels, the attending may also indirectly supervise the upper level resident, being physically within the hospital for consultation on patient care if necessary, but allowing the Resident to work independently, based on the ability of the Resident in the judgment of the attending. Patient based teaching must initially include Direct Observation and interaction between resident and attending including bedside teaching, discussion of pathophysiology and teaching rounds. Attendings will generally oversee procedures by the Residents after having

certified the residents competency in the procedure through Direct Observation. In addition, the attending will oversee and review instruction given to the interns by the resident and provide feedback to the upper level after care or instruction is delivered. The attending will make daily rounds with residents on all patients providing Oversight to the care provided.

Intensive Care Unit (ICU MHH; LBJ)

Each ICU team consists of 4 residents and 4 interns and 1 pulmonary/critical care fellow. Each Resident is paired with one intern comprising a subteam. In this setting interns are indirectly supervised by the attending physician, with direct supervision immediately available, and direct supervision and education of the interns is accomplished through the upper level resident. The primary role of the PGY-2 and 3 residents are to directly supervise and educate the interns and students. The resident will be responsible for Initial evaluation of all patients, including assimilation of old records and outside information, seeing every patient on the day of admission with the intern and dividing the admissions equitably, commensurate with experience level. The upper level resident will review and approve diagnostic and treatment plans with the intern every day prior to Attending Rounds, review patients' progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning. It is expected that the resident and intern will divide up progress note writing responsibility equitably. The Resident is responsible for creating an atmosphere such that the intern is encouraged to ask for help when appropriate. The Resident will directly supervise procedures done by interns. As the intern progresses further into his/her training, the resident should allow the Intern progressively more autonomy through indirect supervision and ultimately observation when the intern is prepared to move to a team lead position.

The upper level Resident on the ICU is directly supervised by the attending physician assigned to his/her team. With the progressive responsibility given to upper levels, the attending may also indirectly supervise the upper level resident as the rotation progresses, being physically within the hospital for consultation on patient care if necessary, while allowing the Resident to work independently, based on the attending judgment in conjunction with the General Supervision policy. Patient based teaching must include direct observation and interaction between resident and attending including bedside teaching, discussion of pathophysiology and teaching rounds. Attending's will generally oversee procedures of the Residents in addition to discussion with the upper level resident about instruction given the interns with feedback provided to the upper level after care or instruction is delivered. The attending will make daily rounds with residents on all patients providing Oversight to the care provided.

Renal Wards and Renal Consults (MHH, LBJ)

Each Renal Ward/Consult team consists of 3-4 Residents and Interns and 1 Renal fellow. The Renal Ward/Consult team comprised of Residents and Interns is also supervised by a Renal fellow in addition to the Renal Attending. In this setting interns are directly supervised and educated by the attending physician, Renal fellow, and upper level resident throughout the day. The primary role of the PGY-2 and 3 residents are to directly supervise and educate the interns and students. The resident will be responsible for Initial evaluation of all patients, including assimilation of old records and outside information, seeing every patient on the day of admission with the intern and dividing the admissions equitably, commensurate with experience level. The upper level resident will review and approve

diagnostic and treatment plans with the intern every day prior to Attending Rounds, review patients' progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning. The attending has direct observation and oversight through the attending rounds that occur daily with the Residents and Interns. It is expected that the resident and intern will divide up progress note writing responsibility equitably. The Resident is responsible for creating an atmosphere such that the intern is encouraged to ask for help when appropriate. The upper level Resident will directly supervise procedures done by interns. As the intern progresses further into his/her training, the resident should allow the Intern progressively more autonomy through indirect supervision and ultimately observation when the intern is prepared to move to a team lead position.

The upper level Resident on the Renal Wards is directly supervised by the attending physician assigned to his/her Renal Ward team in addition to the Renal fellow on duty for the month. With the progressive responsibility given to upper levels, the attending and fellow may also indirectly supervise the upper level resident, being physically within the hospital for consultation on patient care if necessary, but allowing the Resident to work independently, based on the attending's or fellow's judgment. Patient based teaching must include direct observation and interaction between resident and attending or fellow including bedside teaching, discussion of pathophysiology and teaching rounds. Attending's will generally oversee procedures of the Residents in addition to discussion with the upper level resident about instruction given the interns with feedback provided to the upper level after care or instruction is delivered. The attending will make daily rounds with residents on all patients providing Oversight to the care provided.

Hepatology (MHH)

The Hepatology team is comprised of one upper level Residents directly supervised by a Hepatology attending and fellow. Initially the attending and fellow guide the resident with direct supervision of patient care and procedures. With the limited progressive responsibility allotted to upper level resident, the attending may begin to oversee the progress and procedures and the fellow may begin to indirectly supervise the upper level resident, being physically within the hospital for consultation on patient care if necessary, but allowing the Resident to work in a more independent manner. Patient based teaching must initially include direct observation and interaction between resident and attending or fellow including bedside teaching, discussion of pathophysiology and teaching rounds. The attending will make daily rounds with residents on all patients providing Oversight to the care provided.

Emergency Room (LBJ)

Approximately eight (8) interns are sent each month to LBJ for the Emergency Room rotation. The Interns attending is responsible for direct supervision of the Intern, being physically present with the intern during any patient care contact, including but not limited to procedures, bedside teaching, discussion of pathophysiology and teaching rounds.

The ER attendings will initially demonstrate necessary procedures performed and mastered in the ER. After demonstration, the attending will directly supervise patient care and procedures done by the interns and are also responsible for signing off and providing feedback on these procedures.

Cardiology Consults

The Cardiology Consult team consists of 1 Upper Level, 1 Intern and 1 Fellow. The upper level residents are directly supervised by the Cardiology attending and fellow assigned to the rotation for the month. By directly supervising and overseeing the resident while on rotation, the attending is able to utilize this information in the evaluation process to gage the residents progress with regards to to 6 ACGME core competencies. In addition to the attending and fellow, the upper level resident is responsible for direct supervision and education of the Intern on service. After the attending oversees patient care and procedure's completed by a member of the team he/she will provide review of the procedure or encounter with feedback after the care is delivered.

Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Endocrinology Consults

The Endocrinology Consult team consists of 1-2 Upper Levels, 1 Intern, and 1 or more Fellow(s). The upper level residents are directly supervised by the Endocrinology attending and fellow assigned to the rotation for the month. Direct supervision and education of the intern is accomplished through the attending, fellow, and upper level resident. The attending oversees daily patient care and procedure's completed by the resident and is available to provide review of the procedure or encounter with feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Gastroenterology Consults (MHH; LBJ)

The Gastroenterology Consult team consists of 1 Upper Level, occasionally 1-2 interns, and 1 or more Gastroenterology Fellow(s). The upper level residents are directly supervised by the Gastroenterology attending and fellow assigned to the rotation for the month. Direct supervision and education of the intern is accomplished through the attending, fellow, and upper level resident. The attending oversees daily patient care and procedure's completed by the resident or intern and is available to provide review of the procedure or encounter with feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Hematology/Oncology Consults (MDA;MHH;LBJ)

The Hematology/Oncology Consult team at MD Anderson consists of 5 Residents/Interns and 1 or more Heme/Onc Fellow(s). The MD Anderson rotation consists of a combined inpatient and outpatient experience. The Oncology service at Memorial Hermann consists of 1 resident and entails 4 days of outpatient oncology with 1 day of inpatient consults. The Hematology/Oncology Consult team at LBJ consists of 4 Residents/Interns and 1 or more Heme/Onc Fellow(s). The upper level residents and interns are directly supervised by the Heme/Onc attending and fellow assigned to the inpatient and outpatient clinics for the month. Direct supervision and education of the intern is also accomplished through upper level resident. The attending oversees daily patient care and procedure's completed by the resident or intern and is available to provide review of the procedure or encounter with

feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Pulmonary Consults (MHH; LBJ)

The Pulmonary Consult team consists of 1 Upper Level and 1 or more Pulmonary Fellow(s). The upper level residents are directly supervised by the Pulmonary attending and fellow assigned to the rotation for the month. The attending oversees daily patient care and procedure's completed by the resident and is available to provide review of the procedure or encounter with feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Rheumatology Consults (MHH; LBJ)

The Rheumatology Consult team consists of 1 Upper Level and 1 or more Rheumatology Fellow(s). This rotation consists of both inpatient and outpatient clinic settings. One attending is responsible for direct supervision of the residents patient care and procedures in the inpatient and setting and the individual clinic physician is responsible for supervision within the outpatient clinic setting. The upper level residents are directly supervised by the Rheumatology attending and fellow assigned to the rotation for the month. The attending oversees daily patient care and procedure's completed by the resident or intern and is available to provide review of the procedure or encounter with feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

3. Outpatient Services

Neurology

This rotation consists of 2-4 upper level residents. Residents have direct Supervision from their attending for all procedures and patient care. The upper level residents are directly supervised by the Neurology attending and assigned to the rotation for the month. After the attending oversees patient care and procedure's completed by a member of the team he/she will provide review of the procedure or encounter with feedback after the care is delivered.

Geriatrics

This rotation consists of 3-4 upper level residents and 1 or more fellow(s). It is a 4 week rotation with 2 weeks of outpatient clinics and 2 weeks of inpatient. The upper level residents are directly supervised by the Geriatric attending and fellow assigned to the rotation for the month. By directly supervising and overseeing the resident while on rotation, the attending is able to utilize this information in the evaluation process to gage the residents progress with regards to the6 ACGME core competencies. In addition to the attending and fellow, the upper level resident is responsible for direct supervision and education of the Intern on service. After the attending oversees patient care and procedure's completed by a member of the team he/she will provide review of the procedure or encounter with feedback after the care is delivered.

Allergy and Immunology

The Allergy and Immunology rotation consists of 1-2 Residents. Set in Dr. Susan Andrews Outpatient clinic, the allergy and immunology rotation provides an opportunity for PGY2 and PGY3 residents to have basic exposure to the principles in the field of allergy and immunology. Residents in the allergy and immunology rotation will participate in directly supervised patient encounters and discussion sessions with the attending. The resident will be supervised at all times by the attending allergist who will be present on site for consultation. The resident will also have the opportunity to work with nurse practitioners as well as other specialized ancillary staff as they initially view and eventually participate in the various procedures performed in an allergist's office.

Ambulatory

The Ambulatory rotation at MHH consists of 1 upper level Resident at the outpatient clinics located at University of Texas Professional Building. At LBJ there are approximately 2-3 upper level residents and 6-8 interns at the subspecialty outpatient clinics located at the site. The Residents and Interns rotate through these clinics with Direct Supervision from the outpatient clinic attending for the first six months of their internship year. After the expiration of the first six months of their intern year, the Resident and Intern can be indirectly supervised by the Attending Physician. At LBJ, the subspecialty clinic attending may also have fellow for direct supervision of the Residents and Interns. After the expiration of the first six months of their intern year, the Resident and Intern can be indirectly supervised by the Attending Physician.

In the primary care clinics, after the expiration of the first six months of their intern year, the Resident can be indirectly supervised by the Attending Physician, under the primary care exemption. This does not apply to the subspecialty at any site. An attending must be present to directly supervise patient care and Procedures of the Resident and Intern.

Continuity Clinics

The Continuity Clinics consist of 4 residents and interns per attending per clinic session. These sessions take place at the University of Texas Professional Building, Lyndon B. Johnson, West Loop Clinic. Each clinic site serves as the outpatient clinic venue for primary care UT Health faculty. Interns are Directly Supervised for the first six months of their internship year at the clinic and indirectly supervised after under the primary care exemption.

4. Procedures Performed by the Resident

Each Resident will need Direct Supervision while performing any procedure until he/she has completed or assisted in 5 of the following:

1. Resident must demonstrate competence and safe performance of:
    - ACLS
    - Venous/Arterial Blood Draws
    - PAP's
    - Placing Peripheral lines
2. Resident must understand indications, complications, preparation, result, interpretation of:

- Abdominal paracentesis
- Arthrocentesis
- EKG
- Lumbar puncture
- PA catheter placement
- Intubations
- Arterial line placement
- Central venous line placement
- Incision and drainage of an abscess
- Nasogastric intubation
- Thoracentesis

I. ROLES AND RESPONSIBILITIES OF RESIDENTS

As a condition of appointment, the Resident is required, among other things, to:

- Serve as assigned at hospitals affiliated with the Program;
- Accept and perform the duties, responsibilities, and rotations assigned by the Program
  Director;
- Meet the respective Residency Training Program's standards for learning and advancement, including the objectively measured demonstration of the acquisition of
  knowledge and skills as defined by the Program;
- Actively participate in all aspects of their training as directed by the Program Director;
- Abide by The University of Texas System Board of Regents' *Rules and Regulations*, all applicable UT Health policies as set out in the GME Handbook of Operating Procedures(HOOP) (which may be found at https://inside.uthouston.edu/hoop/index.htm, all applicable Medical School policies and Program requirements and guidelines, all Medical Staff Bylaws, and all procedural rules, administrative policies, and other applicable rules and regulations of the hospitals to which the Resident is assigned;
- Participate as a member of hospital, departmental, and institutional committees as directed by the Program Director;
- Conduct himself or herself in a professional manner in keeping with his or her position as a physician; and,
- Meet all other conditions outlined in the this Resident Handbook, the GME Resident Handbook, or as otherwise required by the Program Director and/or Department Chair.

Interns are responsible for the following:

- Initial evaluation of all patients, including assimilation of old records and outside information;
- Developing a plan for each patient to present to his/her Upper Level;
- Communicating with the patient and family about treatment plans, consultations, risks and benefits of procedures and medications, and other aspects of care;
- Getting write-ups on the chart no later than 8:00 a.m. following a call day.

The primary roles of the upper level include supervision and education. This is comprised of the following:

- Seeing every patient on the day of admission and writing an Upper Level Addendum
    1. Upper Level Addendum requires a HPI, pertinent PMH, Meds, and PE, along with the Resident's Assessment of the patient's illness and the team-formulated plan. This is not intended to be a full H&P.
    2. When working with an AI, Resident must write out a full and complete History and Physical, only Medical Students' Review of Systems may be referred to in the Resident note. All other aspects of the H&P must be independently documented by the Resident.
- Review and approve diagnostic and treatment plans with the interns *every day prior to Attending Rounds*
- Review patients' progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning
- Assuming complete responsibility of Interns' patients on Intern days off
- Organizing and planning attending rounds, meetings with consultants, and other teaching opportunities
- Setting time aside for teaching medical students, including reviewing write-ups and giving timely feedback
- Creating an atmosphere such that the intern is encouraged to ask for help when appropriate
- Directly and Indirectly supervising procedures
- Interacting with nurses and other personnel in a way that respects all members of the healthcare team and encourages their input
- Being certain all members of the team are familiar with the current literature regarding their patients
- A Resident will not supervise more than 10 new admissions including in-house transfers; and no more than 16 new patients in a 48 hour period
    1. At MHH on a team with 2 Upper Levels and 2 Interns – the Residents can admit an additional 5 patients
    2. At MHH on a team with 2 Upper Levels and 3 Interns – the Residents supervise 15 new admissions
- A Resident will not be responsible for the ongoing care of more than 14 patients with 1 PGY-1 or 20 patients with 2 PGY-1s
- Participating in Ambulatory curriculum on the day of continuity clinic.

1. Inpatient Services

The inpatient services are organized so as to provide high-quality medical care, allowing the Residents freedom for independent decision-making while retaining direct supervision by the faculty and attending physicians. Most ward teams consist of two interns and one upper level resident. There also may be third and/or fourth year medical students assigned to the team. Each team has a designated teaching attending physician. We encourage acceptance of responsibility and independence of thought on the part of the Residents; however, the ultimate legal responsibility for the care of the patient rests with each patient's attending physician. Therefore, important decision should be made only after discussion with the attending physician, unless a critical situation exists. Each patient should be discussed with the attending physician daily on teaching rounds. The attending physician should be

notified as soon as possible in the event of a patient's death or any important change in medical status (i.e. transfer to the intensive care unit).

Prior to discharge of the patient, the intern should review with the ward resident the diagnoses, inpatient treatment, discharge medications, and plans for medical follow-up. Charts should include all of the following:

1. All primary diagnoses and manifestations have been recorded in the chart
2. All written and verbal orders have been signed by the intern or resident
3. All pertinent physical, laboratory and radiologic findings are documented
4. Daily progress notes have been recorded with the opinion of the attending physician recorded in a note in the chart
5. A Day of Discharge note, including diagnosis, pertinent details of hospital course, discharge medications, and plans for follow-up has been completed
6. The Medication Reconciliation form is completed and signed
7. Core Measures have been addressed
8. The discharge summary has been dictated

The discharge summary must be dictated prior to the discharge of the patient. It should include briefly the reason for entering the hospital, the pertinent points of the history and physical examination, pertinent laboratory and X-ray findings, hospital course, complications, treatment, final diagnosis, discharge medications and instructions, proposed follow-up and the physical condition of the patient at the time of discharge. The summary should be concise, pertinent and well-organized. Copies of the summary should be sent to the patient's private physician, consultants, and the assigned attending physician for the hospitalization. You will not receive credit for a rotation until your dictations are complete

2. Ambulatory Services

The Ambulatory Services consist of ambulatory clinic rotations, resident continuity clinics and subspecialty clinics.

The general medicine clinic LBJ functions as the ambulatory rotation for Interns and select Residents. The clinic is located on the first floor of the LBJ Hospital. Patients will be referred to this clinic from the community clinics for internal medicine consultation, as well as patients who were recently hospitalized who present for follow-up care. If an Intern or Resident has their continuity clinic at another location at the same time, preference is given to the continuity clinic.

In the emergency department and clinics, the intern is responsible for efficient and appropriate medical evaluation of each patient. This includes performance of medical histories and physical examinations, and recording of these clinical data. The intern is also responsible for ordering appropriate tests, and for suggesting disposition for patients in these areas. The intern must check with the resident and/or attending physician on these ambulatory services, prior to the actual disposition of a patient. The intern may also contact the admitting resident and/or attending physician regarding an admission to the inpatient service.

The upper level resident is responsible for contacting the admitting resident and/or attending physician regarding an admission from an Emergency Room or a clinic. If the patient has a private attending physician, the resident must notify him or her prior to discharging a patient from the Emergency Room.

3. General Medicine Continuity Clinic

The goal of the General Medicine Continuity Clinic is to gain and maintain skills in ambulatory internal medicine, including: preventive medicine strategies, knowledge of natural disease processes and experience in a representative office practice. The resident, with the assistance of a faculty member, will be directly responsible for the primary care of each patient assigned to their continuity clinic panel. Teaching will include the process of patient/physician interaction as well as knowledge of specific diagnosis and therapeutic techniques in ambulatory medicine.

Each resident will attend continuity clinic one-half day per week. Continuity clinic may be housed at Quentin Mease, the General Internal Medicine Clinic at the UT Professional Building (Suite 600) or in the General Medicine Clinic at LBJ Hospital. The continuity clinic supersedes all other responsibilities except during rotations in the Medical Intensive Care Unit, Coronary Care Unit or scheduled vacation time. Residents are responsible for rescheduling their continuity clinic if they are post call from a ward team.

If a house officer becomes unable to attend their continuity clinic, he or she must contact the Chief Medical Resident, their clinic attending and the clinic scheduler as soon as possible so patients may be rescheduled. Any communication other than telephone is unacceptable.

A house officer may refer his hospital patients to his own continuity clinic for hospital follow-up, with the clinic attending's approval. Patients may be self-referred or the Emergency Room and other departments at Memorial Hermann Hospital and LBJ Emergency Room may refer patients for evaluation. Patients of house officers who have completed their training will be reassigned to other house officers. The number of patients scheduled during each continuity clinic will increase commensurate with PGY level. All residents will be expected to be in clinic during their scheduled time, whether or not they have patients scheduled.

The faculty will review each case history and examine every patient with the resident while in the continuity clinic. Each chart should have an up-to-date problem list and list of medications. Routine health maintenance will also be performed.

4. Subspecialty Clinics

When rotating on a subspecialty consultation service, residents are encouraged to attend one-half day per week of that subspecialty clinic. The specific clinic location and time are up to the discretion of the service Attending.

J. HOSPITAL ADMISSIONS

1. Memorial Hermann Hospital

The Emergency Room attending physician has full authority to admit patients to the internal medicine services. The service to which the patient will be admitted will be dictated by the patient's major problem or underlying disease. Once you have evaluated the patient, if you disagree with any decisions from the ER, call your attending to discuss the case. Any disagreement over patient care or disposition should be referred to the Medicine Attending for appropriate action.

If a patient has a PCP, including General Medicine faculty or Residents clinic, the PCP should be notified of the admission and plans for management.

2. Lyndon B. Johnson General Hospital

At the LBJ Hospital, attending physicians are members of the Medical School faculty, assigned on a monthly basis. As at Memorial Hermann Hospital, the LBJ attending physician has the ultimate responsibility for the patient. The Resident must maintain daily communication with the attending physician regarding the progress of all patients on the service.

3. M.D. Anderson and St. Luke's Hospitals

Patients at these hospitals usually have an attending physician who has initiated the admission. Just as at Memorial Hermann Hospital, the attending physician should be notified promptly of the admission, and the patient should be discussed with the attending physician at least daily thereafter.

4. Call Rooms and Food Services

Residents on call will have access to clean, adequately lit call rooms for study or sleep with available bathroom facilities. Additionally, Residents will have access to food services while on duty at affiliated institutions.

K. PROCEDURES AND SKILLS

PGY-1:

1. An intern performs a history and physical exam on each patient admitted to them. They follow the patient closely while admitted to the hospital with daily progress notes and discharge summaries at the end of the hospitalization.
2. Writes all orders on their patients.
3. Performs procedures necessary for the care of their patients with supervision and under the direction of the attending physician. Although an attending physician is on call to assist the Housestaff, the following duties may be performed without the presence of the attending physician with the guidance of a PGY-2, PGY-3 or PGY-4 Housestaff or fellow who has been appropriately credentialed to perform these procedures:
    a. Lumbar Punctures
    b. Thoracentesis
    c. Central Line Placement
    d. Paracentesis
    e. Arthrocentesis of knee joint
    f. Arterial puncture for blood gas analysis
    g. Critical life-saving procedures
    h. Nasogastric intubations
4. Supervises and helps in teaching the third and fourth year medical students.
5. Participate on teaching rounds with the residents and the intern(s) and attendings on a daily basis.

PGY-2/PGY-3/PGY-4:

1. A resident performs a history and physical exam on each patient admitted to them. They supervise and follow the patient closely while admitted to the hospital.
2. Writes orders on their patients and oversees intern orders on patients

3. Performs procedures necessary for the care of their patients with supervision and under the direction of the attending physician. Although an attending physician is on call to assist the resident, the following duties may be performed without the presence of the attending physician. These include:
    a. Lumbar Punctures
    b. Thoracentesis
    c. Central Line Placement
    d. Paracentesis
    e. Arthrocentesis of knee joint
    f. Arterial puncture for blood gas analysis
    g. Critical life-saving procedures
    h. Nasogastric intubations
4. The following procedures must be done with the direction and supervision of an attending physician. These include:
    a. Swan-Ganz Placement (ICU or CCU)
    b. Bone marrow aspirate and biopsy (Pathology attending physicians)
5. Supervises and helps in teaching the third and fourth year medical students as well as the intern.
6. Pre-round with the interns daily
7. Participate in teaching rounds with the intern(s) and attendings on a daily basis.

Interactions with Residents constitute a major source of learning for medical students and other Residents. The educational tone of a service is set largely by the ward resident and the interns. Therefore, residents and interns have a major obligation to teach. Moreover, teaching is the best method of active learning. Teaching allows the house officer to think aloud. During the teaching interaction, new questions usually arise, so the teaching process stimulates further exploration of knowledge. We therefore consider every set of work rounds to be an extremely important educational experience. Every new admission should, within the restraints of appropriate patient care, be considered an opportunity for the Residents to teach each other and the students. The residents' teaching rounds are generally viewed by the students as enjoyable and profitable educational experiences.

Junior medical students are expected to have acquired the following basic skills and knowledge by the end of their three months on internal medicine:

- ability to take an accurate medical history and to perform a careful physical examination;
- ability to examine and interpret peripheral blood smears and urine sediments
- ability to understand the fundamentals of interpretation of electrocardiograms, and films of the chest, abdomen and kidneys;
- ability to synthesize clinical data into a problem list with a reasonable differential diagnosis;
- ability to understand the pathophysiologic basis of the manifestations of disease, and the scientific basis of treatment;
- ability to keep concise, meaningful, complete and accurate medical records which objectively document the status of the patient;
- ability to perform the following procedures correctly: Venipuncture, insertion of peripheral venous lines, arterial puncture for blood gases, insertion of urinary catheters, rectal and pelvic examinations, basic cardiopulmonary resuscitation (airway, ventilation and chest compressions)

Residents are expected to help students achieve the above abilities and skills by allowing students to see patients first unless the situation is urgent. Residents should observe the students performing histories and physical examinations during the early part of the rotation, in order to recognize and correct any deficiencies. Residents should discuss historical, physical and laboratory findings with the students. The resident should review the students' recorded histories and physicals. Residents and interns should instruct and supervise the students in basic procedural skills. On regularly scheduled teaching rounds, the resident should point out abnormal physical findings, discuss pathophysiology of disease and the scientific basis of treatment. Housestaff should guide the students and interns to appropriate reading material. Finally, the Residents should always treat junior students respectfully, as valued members of the inpatient health care team.

K. MEDICAL RECORDS AND CLINICAL DOCUMENTATION

It is the responsibility of every house officer to complete all medical records in a timely manner. The Ward resident is ultimately responsible for all documentation completed by the team during his/her month whether it is documented by himself/herself, an intern or acting intern (4th year Medical Student). It is the responsibility of the ward Resident to complete admission history and physical examinations and discharge summary dictations. Interns should dictate discharge summaries on the day the patient is discharged. If a discharge summary becomes delinquent, the record will be turned over to the ward resident for completion. Medical students, including 4th year students, must not dictate discharge summaries. Notification of incomplete charts will occur on a regular basis, and the intern/resident must then complete those charts within 1 week. Failure to do so will result in disciplinary action.

It is the responsibility of consulting residents to complete consultation note dictations within 24 hours of performing the consultation.

L. EXPOSURE TO INFECTIOUS DISEASES

Needle Stick and Other Exposures – Including Body Fluids

1. If you have a needle stick or other body fluid exposure go to the Memorial Hermann Hospital Emergency Room. The attending will instruct you as to the course of action depending upon the type of exposure you have had. For 24-hour immediate assistance, information, or counseling contact **713-951-8013 (pager)** and leave message. Your call will be handled immediately.

2. You must complete a First Report of Injury Form. This form establishes the eligibility for Workers Compensation Insurance. The First Report of Injury Form will be available through the ER attending.

3. For follow-up it will be necessary for you to be seen in the UT Student Health Services Clinic. Follow-up will be determined by the EC Attending.

4. If you are significantly exposed to HIV and you choose to take prophylactic antiretroviral medications, they will be prescribed and made available at the Memorial Hermann Pharmacy. The Pharmacy will bill the Medical Foundation if the

prescription is written by an ER attending or the physician in the Family Practice Health Clinic.

5. It is YOUR responsibility to follow the above steps and complete all forms for incident reporting. Follow-up with the health clinic is mandatory to be in compliance with worker's compensation regulations. This is very important so that claims can be filed with Worker's Compensation and not billed to you.

M. EVALUATION AND ADVANCEMENT

Residents must successfully complete clinical and didactic requirements in order to be promoted to the next level as well as to successfully complete the program. The decision to appoint and reappoint will be based on performance evaluations, participation in conferences and lectures, mastery of the six core competencies delineated by the ACGME, and an assessment of the resident's readiness to advance.

Each attending is reminded that at the beginning of the month, he/she is to go over the goals and objectives with his/her Resident(s) and explicitly outline what is expected of the Resident throughout the month. Mid-month each resident shall meet with their attending physicians to review his/her progress. At the end of the month, the resident and attending shall meet to review the evaluation. On each rotation, the Resident's performance is evaluated by the attending physician through an on-line evaluation system, GMEIS. Before an evaluation is considered complete, it must be acknowledged or protested on-line by the resident.

Resident evaluations are available online at the end of the month and email reminders will be automatically sent to each resident and attending. The attending will fill out his or her evaluation on the resident and the resident will fill out an evaluation on both the attending and the rotation. When a resident has completed his/her evaluation of the attending, he/she will be able to view the comments made by the attending physician applicable to the rotation. Residents are given the opportunity to respond to comments made by the attending, if they wish. The evaluations are sent out on the 25th of each month and requested to be completed before the 9th of the following month.

Residents will also be asked to evaluate other residents, interns, fellows and medical students that they work with each month.

The online evaluation system developed by UT Health can be found at: https://gmeis.uth.tmc.edu/gmeis/index.jsp

Evaluation of advancement of the Residents is performed by the Chairman and Program Directors, with the advice of the Internal Medicine Directors at M.D. Anderson and St. Luke's hospitals, and the Assistant Chiefs of Service. These reports are printed and kept in the resident's permanent file in the Residency Program office. A resident may review that file any time he or she wishes. Progress of residents is reviewed regularly by the Residency Clinical Competency Committee, which meets monthly.

1. Resident Evaluations

Resident evaluations occur on a monthly basis and are completed by the appropriate attending. The evaluations are an analysis of the Residents performance during the month based on the 6 ACGME core competencies. These evaluations are assigned 7 days after the beginning of each rotation. Any rotations where a resident received an overall rating of "Unsatisfactory" will need to be repeated.

2. Rotation Evaluations

Rotation evaluations are assigned on a monthly basis and completed by the Resident. The rotation evaluations are an opportunity for the Resident to evaluate their experience on each rotation with an assessment of patient diversity, workload, responsibility, and supervision amongst other things. The Program Director utilizes these evaluations in his/her review of the Programs curriculum.

3. Peer Evaluations

Peer evaluations are assigned monthly and completed by the Resident on his/her peers conduct throughout the rotation. It is completed and submitted by team members that rotated with the resident for the month and can be submitted confidentially. These evaluations are reviewable by the individual being evaluated however, if it is submitted anonymously, the reviewing neither the reviewing Resident nor any Program Director or administrator will not be able to determine who submitted the evaluation.

4. Attending Evaluations

Attending evaluations are assigned on a monthly basis Residents evaluations of their attending for the month that the Resident worked with him/her. This evaluation can be completed anonymously by the Resident and gages the attending's availability, teaching ability, patient care and professionalism, medical knowledge, support for the resident and attending feedback.

5. Resident Self-Evaluations

This self assessment is completed by the resident at the end of his/her training and discussed with them in their end of year evaluation meeting with the Program Director. The program Director has also completed an assessment of the Resident to compare.

6. Six Month Evaluations

These evaluations are completed by the Program Director/Associate Program director are provided to the Resident at least semiannually and each Resident is provided feedback about their progress in the program. The summary presented to the Resident details the residents progress over the previous six month period. Career counseling is also discussed in this meeting. This meeting is documented in the GMEIS system and a copy of the meeting details is placed in the Residents file.

7. Clinical Evaluation Exercise

During the PGY-1 year, the clinical skills of each resident will be formally evaluated by a member of the faculty. This exercise requires that the faculty member observe the resident perform a history and physical examination, and then discuss the diagnosis and plans for management with the house officer. If the evaluating physician believes that further improvement of clinical skills is desirable, the exercise will be repeated at later stages of training. Satisfactory completion of the Clinical Evaluation Exercise is required before we will declare the house officer to be eligible for the examination of the American Board of Internal Medicine.

Each resident will receive an email within the first week of September with the CEX form attached which will include instructions for completion and will be due no later than the last day of October. It is the residents responsibility to print out the form, take it to the

assigned clinic attending, or hospital attending, and have it completed. After both the attending and resident sign it, it should be delivered to the Program Coordinators.

8. In-Training Exam

The In-Training Examination by the American College of Physicians is mandatory for all residents. It is administered in October of every year and PGY-2 and 3 categorical residents will sit for the exam each year. You will be excused from clinical duties on that day and you will take the 8 hour exam in two sessions.

9. Problems and Complaints about Evaluation

If a resident received an unsatisfactory evaluation from any attending physician, one of the program directors will discuss the matter both with the attending physician and the house officer. The outcome of these meetings will be improved understanding of what is expected of the house officer and, if necessary, plans for improvement of performance. Written records of these discussions will be kept in the house officer's file. If there are issues that come up during a rotation, the resident should discuss it first with the attending and then, if necessary, with a program director.

In the event that a patient, house officer, faculty member, member of the hospital administration or nursing staff registers a complaint regarding a member of the Resident, that complaint will be investigated thoroughly. If there appears to be substance to the complaint, the house officer will be asked to discuss the situation with one of the program directors. If desired, the house officer may write a formal rebuttal which will become part of his or her record. If the program director concludes that the complaint was unjustified, no further record will be maintained of the incident. If it is concluded that there has been misconduct warranting disciplinary action, that action will be subject to the rules set forth by the Medical Foundation and outlined explicitly in the resident's contract.

10. Retaliation

The Program encourages Resident's and Attending's to open and honestly evaluate as is appropriate in the spirit of constructive evaluation. This program does not condone or tolerate retaliation. Should a resident feel that he/she is being retaliated against for any reason, this should be reported to a Program Director immediately for review and proper action.

N. Medical Licensure

Eligibility requirements for Texas Medical licensure are found in Chapter 163 of the Texas Medical Boards rules. The major requirements for completion of either 60 hours of pre-medical education or completion of the required pre-medical education of the country where the medical school is located, graduation from a U.S. or Canadian medical school or an acceptable unapproved medical school, and you must have passed an examination acceptable to the Board. Graduates of foreign medical schools will become eligible for licenses after three years of residency training. Licensure information may be obtained from the house staff office. Complete information about licensure can be found on the Texas Medical Board webpage at http://www.tmb.state.tx.us/apps/physician_eligibility.php. Housestaff should obtain a valid Texas Medical License as soon as possible.

If you are licensed while still completing residency training, you must maintain your license and ensure that the Residency Program has your current information. If you allow your license to expire, you will be unable to perform your Residency duties until it is renewed.

1. DEA AND DPS NUMBERS

Institutional Drug Enforcement Administration (DEA) numbers are assigned by the affiliated hospital to the Resident. The institutional DEA number allows prescription-writing privileges for only educational training program activities. Institutional DEA numbers are not valid for "external moonlighting" or any other activities outside of the educational training program. Institutional Department of Public Safety (DPS) numbers are assigned to Residents that hold a Texas Medical Board PIT permits. These numbers are assigned by the GME Office in coordination with affiliated hospitals. The DPS number allows prescription-writing privileges for controlled substances only as part of educational training program activities. DPS numbers are not valid for "external moonlighting" or any other activities outside of the educational training program.

Once a Resident obtains a full, unrestricted Texas medical license, the licensed Resident must apply for and obtain individual DPS and DEA numbers. All fully licensed Residents are responsible for obtaining their own individual DPS and DEA number

O. EDUCATIONAL MEETINGS AND CONFERENCES

The Program has taken great care in putting together a comprehensive list of didactic lectures and conferences to help you in your studies. Scholarly activities are encouraged among the residents. Part of this is attendance at national meetings for Internal Medicine or its subspecialties. Residents who wish to attend medical or scientific meetings must obtain prior approval from their attending physicians and the program director. Coverage for your absence from service must be arranged by the resident ahead of time. The Assistant Chiefs of Service will not pull residents from the Jeopardy Call Pool to provide coverage for a resident's duties while they are away.

There are several Internal Medicine conferences held weekly. Attendance by Residents is mandatory and will be monitored with sign-in sheets. Failure to maintain 80% attendance to Noon Conference and Morning Report, excluding days off, post call days, or attendance to a subspecialty conference (held at the same time) will result in punitive action.

Conference attendance will be tallied from the first of each month to the last day of each month. Cumulative attendance rate will be available on the 1st day of the following month. Any housestaff with less than 80% attendance rate will be required to do the following:

> 1st Violation: Housestaff will meet with their assigned Associate Program Director, have a letter placed in their file, and be assigned extra jeopardy calls and/or on the holiday jeopardy call pool.
>
> 2nd Violation: Housestaff will be required to appear before the Residency Competency Committee, followed by a letter which will be formulated and submitted to the Texas Medical Board.

These mandatory conferences are as follows :

1. **Resident Case Conferences**

These conferences include resident intake report, intern conference, sub-specialty conference, and post-call morning reports. Conferences occur at both hospitals and will be clinical case presentations by the residents or interns scheduled for that day. Attendance at these conferences is required and will count toward your total attendance for the month.

2. **Core Curriculum Lectures**

This one-year series of lectures is delivered by the Core Faculty/Core Faculty designee. Each subspecialty presents on commonly seen disease processes in Internal Medicine and these presentations are designed to prepare Residents for practice as well as for the American Board of Internal Medicine Certifying Examination. These structured conferences along with consistent reading, attendance at other conferences and patient care help prepare Residents for the Board examination.

3. **Grand Rounds**

Internal Medicine Grand Rounds are held on Thursdays at 8:00 AM in the Medical School 2.103. These presentations are given by members of UT Health faculty or by visiting professors, concerning important and relevant topics in Internal Medicine. This conference is simultaneously broadcast to LBJ hospital.

4. **Senior Seminar**

Every year, the senior residents prepare noon conferences that consist of a review of a topic. The subject matter may be any topic relevant to clinical medicine or the basic sciences which relate to medicine or delivery of health care. The presenting residents are expected to use the PowerPoint presentation format and to distribute handouts outlining the subject and containing pertinent bibliographies. Each resident will present once during his/her PGY-3 year and select a faculty mentor to assist with this presentation. Residents may be exempt from this requirement if they have presented at an ACP conference or have a publication during their residency.

5. **Morning Report**

Morning Reports are offered Mondays from 1-2 and Wednesdays and Fridays from 1-1:40 PM at the Medical School Building (for those rotating at Memorial Hermann) and in the UT Annex building (for those rotating at LBJ Hospital). These conferences are designed to bolster critical thinking on the part of the Residents by developing presentation skills as well as refining their clinical approach to patient problems. Residents and Interns are responsible for presenting clinical cases for discussion.

6. **Multidisciplinary Week**

One week of the month will dedicated to multidisciplinary conferences including radiology, pathology, quality improvement, journal club, and research conferences. Attendance at these conferences is required and will count toward your total attendance for the month.

P. PROFESSIONAL ATTIRE AND ETIQUETTE

Resident's should always dress and behave in such a way as to earn the respect of patients, nurses, students, fellow physicians, and other hospital personnel. White coats should be worn on the wards and in the clinic; the names embroidered on the coats should be clearly and easily visible. Residents are expected to dress in professional attire and to demonstrate good personal hygiene and cleanliness. Scrubs may be worn on weekends and "after hours" during on call shifts.

Residents should always have a business cards handy to distribute to patients in an effort to cultivate strong patient-physician communication. If you do not have the appropriate University of Texas business card for yourself, these can be retrieved from the Housestaff office by a coordinator.

Q. MOONLIGHTING

Moonlighting is defined as any patient care service a Resident performs as a fully licensed physician where he/she receives financial compensation as a result of those services. Moonlighting occurs outside of the Internal Medicine Residency Program and Residents assignments from the Program are not included in Moonlighting. Residents are *not required* nor are they encouraged to engage in professional activities outside the educational program. Moonlighting must not interfere with the ability of the resident to achieve the goals and objective of the program.

Every resident who wishes to engage in moonlighting must provide written notification of their intent and participation to the Program Director and receive approval from the Program Director. This request and approval/disapproval will become part of the Residents file. Failure to notify the program director of moonlighting activities will result in disciplinary action. The Program may revoke approval or initiate corrective action in the event outside professional activity interferes with the ability of the Resident to satisfactorily fulfill the obligations of the Program.

Residents are required to be independently licensed for unsupervised medical practice by the State of Texas and be in good standing with the Residency Program before they can consider moonlighting. A physician-in-training permit <u>does not</u> entitle the Resident to engage in professional activities (i.e., medical practice) outside the educational program. Moonlighting is prohibited during standard work hours and should be limited to no more than 3-4 nights per month, and cannot interfere with performance of one's clinical and academic duties. All moonlighting will count toward the resident's total duty hours and residents may not exceed 80 hours worked per week.

The University of Texas Health Science Center does not provide liability coverage for moonlighting activities. It is the responsibility of the hiring institution to determine whether the resident has the appropriate licensure in place, whether adequate liability coverage is provided and whether the resident has the appropriate training and skills to carry out assigned duties.

Interns are not permitted to moonlight under any circumstances.

R. DUTY HOURS

Duty Hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to

patient care, the provision for transfer of patient care, time spent inhouse during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Night Float is defined as a rotation or educational experience designed to either eliminate in-house call or to assist other residents during the night. Residents assigned to night float are assigned on-site duty during evening/night shifts and are responsible for admitting or cross-covering patients until morning and do not have daytime assignments. Rotation must have an educational focus. Residents must not be scheduled for more than six consecutive nights of night float. Programs must further abide by any program specific requirements.

1. Policy

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. Duty periods for PGY-1 residents must not exceed 16 hours in duration. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. The program encourages residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly encouraged.

(i) Residents may be allowed to remain on site in order to ensure that effective transitions occur, however this period of time must be no longer than an additional four hours.

(ii) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or an unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

- a. Under those circumstances, the resident must:
  - i. appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
  - ii. document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
- b. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Residents must be scheduled for a minimum of one day free of duty every week when averaged over 4-weeks. At home call cannot be assigned on these free days. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

Minimum Time Off Between Scheduled Duty Periods: PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. Intermediate-level residents should have 10 hours free of duty, and must have eight hour between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended

periods. This preparation must occur within the context of the 80- hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. PGY-2 residents and above must be scheduled for in-house call no more frequently than every third night, averaged over a four-week period. PGY-2 residents and above must not be assigned additional clinical responsibilities after 24 hours of continuous duty

Duty Hours are formally monitored through the Institutional GMEIS system and each Resident is required to submit their duty hours on a monthly basis.

2. On-Call Activities

At-home call (pager call) is defined as call taken from outside the assigned institution. At-Home Call may not be scheduled on the resident's one free day per week (averaged over four weeks). At-home call does not occur during the Medicine Residency.

1. Time spent in the hospital (exclusive of travel time) by residents on at home call must count towards the 80 hour per week limit.
2. The frequency of at-home call is not subject to the every third night limitation, but must satisfy the requirement for 1 day in 7 free of duty when averaged over a 4-week period.
3. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
4. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".

In-house call does not occur more frequently than every third night, averaged over a 23 four-week period. Continuous on-site duty, including in-house call, will not exceed 24 consecutive hours however Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as appropriate.

3. Subspecialty Program Requirements

While on a subspecialty rotation, no new patients may be accepted after 24 hours of continuous duty. At-home call (pager call) is defined as call taken from outside the assigned institution. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

4. Professionalism, Personal Responsibility, and Patient Safety

All Residents and Interns in the Internal Medicine Residency Program must appear for duty appropriately rested and fit to provide the services required of patients. This is not only important for professional aspects of your job but also to ensure patient safety while you are practicing patient care. The S.A.F.E.R program, provided by the GME office, is a required presentation that each Housestaff officer must view and understand. This presentation is designed to educate Residents and Interns to recognize the signs of fatigue and sleep deprivation, educate in alertness management and fatigue mitigation processes, helps with ideas on how to mitigate patient care problems that stem from fatigue. Residents and Interns are strongly encouraged to notify the attending and/or Program Director of issues with fatigue while completing patient care responsibilities and encourages the use of strategic napping to fight the effects of fatigue on Patient Care. Sleep facilities are provided at all sites where a Resident or Intern rotates and may find themselves in a situation where the patient care quality is compromised by excessive sleepiness.

S. GRIEVANCES

The Program Director is responsible for ensuring compliance with this grievance and dues process procedure as well as the institutional requirements found in the GME Resident Handbook. Grievances may involve payroll, hours of work, working conditions, clinical assignments, and issues related to the program or faculty, or the interpretation of a rule, regulation, or policy. The grievance process is not intended to address any aspect of the evaluation of academic or clinical performance or professional behavior, or other academic matters relating to failure of the resident to attain the educational competencies of the Program.

If a Resident has a grievance, he or she should first attempt to resolve it by consulting with (1) the Chief Resident; (2) the Program Director; or (3) the Department Chairperson. If the matter is not resolved to the Resident's satisfaction, the Resident should then present the grievance in written form to the DIO through the GME office.

A grievance subcommittee of the GMEC appointed by the DIO will be assigned to review the grievance. The Resident may be invited or permitted to appear before the subcommittee at the discretion of the subcommittee. After the grievance subcommittee has reviewed all information submitted in writing or in person by the Resident, a decision will be communicated in writing to the Resident and other appropriate, involved persons. The decision of the subcommittee is final.

T. CORRECTIVE AND/OR ADVERSE ACTIONS

1. Summary Actions when Resident May Pose a Threat to Patient Safety

Under any circumstances in which the Program Director or the clinical department's Education Committee determines that the unsatisfactory performance and/or any conduct of a Resident may constitute an immediate threat to patient safety, the Program Director may reassign or suspend the Resident pending a determination by the Program Director regarding the ability of the Resident to continue in the Program. If the Program Director's determination regarding whether the Resident is able to continue in the Program is appealed, the appeal shall be conducted under the provisions for "Academic Actions" below, except that the Resident need not have been provided prior "notice and guidance" regarding the conduct prompting the summary suspension.

2. Academic Actions

In the event a Resident encounters difficulty meeting and/or maintaining performance standards as they pertain to the ACGME Competencies, as well as/or professional behavior standards ("academic difficulty"), the Program Director will notify the Resident that his/her performance is unsatisfactory. Likewise, if a Resident is having academic difficulty, he/she should seek the guidance and advice of the Program Director.

If after the Resident has been notified about his or her unsatisfactory performance, and been offered advice, guidance, and, if appropriate, a corrective plan, but continues to be less than satisfactory, the Program Director, at his or her discretion, may take appropriate academic corrective and/or adverse action. Corrective/adverse actions include, but are not limited to remedial assignments, letters of warning, probation, suspension, non-promotion, non-reappointment, or dismissal from the Program.

In cases where a Resident has been notified of non-promotion, non-reappointment, suspension, or dismissal and believes that such action was levied without the appropriate notice and guidance that would have enabled the Resident to improve his or her performance prior to the corrective/adverse action, the Resident may request that a subcommittee of the GMEC be established to review such action. The Resident must make a written request for review of this decision to the DIO within 14 days of the date that the academic corrective/adverse action in question was levied against the Resident.

The subcommittee review will generally be scheduled within 30 days of the resident's request for a hearing. The hearing panel will consist of at least three members of the GMEC. The DIO will determine the date of the hearing in consultation with the resident and program leadership. The hearing will be presided over by the chairperson selected by the subcommittee. The conduct of the hearing is at the discretion of the chairperson.

The review by the GMEC subcommittee is restricted solely to the determination of whether the requisite notice and guidance was provided by the Program Director to the Resident.

A final decision will be made by a vote of the subcommittee and will be communicated to the resident within 10 working days after the hearing. Within 10 days after the parties have been notified of the decision, either party may give written notice of appeal to the Dean of the Medical School. The Committee's decision will be reviewed by the Dean, who may accept or reject the Committee's decision or may require that the original hearing be reopened. The action of the Dean shall be communicated in writing to the Resident and Program Director as soon as reasonably possible. The decision of the Dean is final.

3. Non-Academic Actions

In the event allegations of unethical conduct, scholastic dishonesty, theft, or any conduct prohibited by UT Health, The University of Texas System, federal, state, or local law are levied against a Resident, the Program Director or the Foundation may take corrective/adverse action against the Resident, including, but not limited to termination of the appointment of the Resident prior to the end of the appointment term.

If allegations are levied against the Resident that (if confirmed) may subject the Resident to corrective/adverse action, the Program Director will conduct an investigation into the allegations in cooperation with the GME Office or other appropriate office(s). If the investigation substantiates the allegations, notice of the allegations will be delivered by the Program Director to the Resident *via* hand delivery or certified mail with a copy to the GME office.

Upon receipt of a notice of allegations from a Program Director, the GME office will promptly provide a copy of the following procedures to the Resident.
If the Resident does not dispute the allegations, he or she will be asked to sign a Waiver of Hearing and a disciplinary penalty may be assessed by the Program Director or Department Chairperson. If the Resident disputes the allegations, or if the Resident admits the allegations but contests the penalty to be assessed, he or she may request a hearing before a Discipline Committee appointed by the DIO.

The Discipline Committee will consist of three members, one of whom will be a Resident member from a Residency Training Program. The Committee will select its presiding chairperson. The Resident will be given at least 10 days notice of the date, time, and place for such hearing, and names of the members of the Committee. The notice will include a written statement of the allegations and a summary statement of evidence alleged to support such allegations. The notice shall be delivered in person or by certified mail and regular U.S. mail to the Resident at the address appearing in the Program records.

The Resident may challenge the impartiality of any member(s) of the Committee up to three working days prior to the hearing. The challenged member(s) of the Committee shall be the sole judge of whether he or she can serve with fairness and objectivity. In the event a member disqualifies himself or herself, a substitute will be chosen.
At a hearing on the allegations, the Program representative has the burden of going forward with the evidence and the burden of proving the allegations by the greater weight of the credible evidence. The following shall apply:

1. Each party will provide to the GME office a complete list of all witnesses, a brief summary of the testimony to be given by each, and a copy of all documents to be introduced at the hearing. Each party will be provided copies of the above by the GME office prior to the hearing. Deadlines concerning the submission of materials will be set and communicated by the GME office.
2. Each party will have the right to appear and present evidence in person. The Resident may have legal counsel present outside of the hearing room; however, no attorneys will actually appear as an advocate for either party.
3. Each party will have the right to examine witnesses on relevant matters.
4. The hearing will be recorded. If either party wishes to appeal the findings, the record will be transcribed and both parties will be allowed to purchase a copy of the transcript.

The Committee will render and send to both parties a written decision, and at its discretion may impose a penalty or penalties.

Either party may appeal an action taken by the Committee in accordance with the following procedures:

Within 14 days after the parties have been notified of the decision, either party may give written notice of appeal to the Dean of the Medical School. If the decision is sent by mail, the date the decision is mailed initiates the 14-day period. The Committee's decision will be reviewed by the Dean solely on the basis of the transcript and evidence, if any, considered at the hearing. In order for the appeal to be considered, all necessary documentation, including written argument, must be filed by the appealing party with the Dean within 14 days after notice of appeal is given and the transcript is available.

The Dean may approve, reject, or modify the Committee's decision or may require that the original hearing be reopened for the presentation of additional evidence and reconsideration of the decision. The action of the Dean shall be communicated in writing to the Resident and Program Director no more than 30 days after the appeal and related documents have been received. The decision of the Dean is final.

4. Duty to Report

The TMB requires all Residents with PIT permits to report, in writing, the following circumstances to the Executive Director of the Board within 30 days of their occurrence:

- the opening of an investigation or disciplinary action taken against the PIT permit holder
  by any licensing entity other than the Texas Medical Board;
- an arrest, fine (over $250), charge or conviction of a crime, indictment, imprisonment,
- placement on probation or receipt of deferred adjudication; or
- diagnosis or treatment of a physical, mental or emotional condition which has impaired or
  could impair the PIT permit holder's ability to practice medicine.

Failure to comply with the provisions of this chapter (22 Tex. Admin. Code, Section 171) or Tex. Occ. Code, Sec. 160.002 and 160.003 may be grounds for corrective action, including disciplinary action.

U. CONDITIONS OF SEPARATION

1. Resignation

A Resident may resign from a Program by providing at least 30 days' written notice of his/her intent to resign. The Resident's resignation must be submitted to the Program Director. All conditions of appointment will terminate on the effective date of the resignation. At the discretion of the Program Director, a resignation may be accepted effective immediately, notwithstanding the proposed effective date provided by the Resident.

2. Separation

Separation may occur at the end of an appointment term under any circumstances in which reappointment does not occur, including successful graduation from the program.

3. Termination

A Resident's appointment may be terminated prior to the end of the appointment term. A Resident so terminated will generally receive compensation equivalent to 90 days' salary.

V. PAGERS

Residents are issued a personal pager, for which they are financially responsible for the loss or damage of. In addition to the pager issued by the Program, Housestaff may be issued a hospital pager during rotations at MD Anderson or St. Luke's Episcopal Hospital. Residents are **required** to wear your UT pager and leave it on at all times unless on vacation or your day off.

Residents are required to return all pages in a timely manner (i.e. under 5 minutes). It is understood that there are times when you may be in the middle of a procedure, at those times, please return pages as soon as possible.

When paging, please exercise pager courtesy, which is to put the full 10 digit number into the pager, hit the asterisk button (*) and put your pager number in, before hitting pound (#) to send the page.

The pager systems are as follows for each hospital:

Memorial Hermann and LBJ Pagers:
Dial telephone number 713-605-8989. After the beep, enter the 5 – digit beeper number. Then, enter the return number and press the # sign. Or call the Hermann Page Operator at 713-704-4884.

M.D. Anderson Pagers:
From an outside line, dial 713-792-7333, then ####.
From a 792 or 794 line, dial 2-7333, then ####.
When instructed, enter the call back number.
M.D. Anderson Page Operator: 713-792-7090

St. Luke's Pagers:
Within SLEH dial 12345, or 713-605-8989 from the outside. At the tone, enter the five digit pager number and wait for another tone. After the beep, enter the return number, followed by the # key. St. Luke's Page Operator: 713-791-4146

W. EMAIL

After satisfying all prerequisites, completing all paperwork relevant to appointment and signing the *User Responsibilities & Accountability Acknowledgment Form,* a Resident will be assigned a UT Health e-mail address and allowed permitted use of UT Health computer resources, particularly e-mail, during the duration of their appointment. Residents are subject to and shall abide by the terms of all applicable information technology policies and guidelines contained in the UT Health HOOP (see, e.g., HOOP Policies 98, 132, 175-181, and 198). All use of the UT Health information technology network, including access to and use of the internet and UT Health email is a privilege that must not be abused. Any prohibited or inappropriate use of the network and/or the e-mail system may result in the withdrawal of such privilege, and may be grounds for additional adverse action, up to and including dismissal from the Program.

The UT Health email will be the only email address that the Program will disseminate information to and through. It is the Resident's responsibility to check his/her UT Health account on a regular basis with the recommendation being daily. Residents will be held responsible for any information disseminated via email, regardless of whether it is checked frequently or infrequently. The UT Health e-mail is web-based and can be reached by any computer connected to the internet at the following URL: https://webmail.uth.tmc.edu/. If you experience problems with your account or password, please contact the UT Health Help Desk at 713-486-4848.

Residents are encouraged to disseminate information to each other via email in the form of interesting articles, etc. However, one must remember to be HIPAA compliant in using one's email. You may not include patient names or medical record numbers in emails. You

must also make sure that whenever you are emailing presentations or radiographic studies that names and medical record numbers, in addition to accension numbers are removed from x-rays and other studies, even if they are imbedded in power point presentations.

In addition, please be judicious in using the *Reply All* function of email. Please be careful about your wording of information, especially about other individuals—be aware that your emails (even deleted ones) are archived and written comments about others may be consider libel.

X. LAB COATS

Four three-quarter length coats are supplied to each Resident through the Program in the first appointment year, and one additional coat is supplied in each subsequent year of training. Information about laundry services is available from the Housestaff Office located at MSB 1.134.

Y. PARKING

Subsidized parking is available to Residents in the UT Professional Building and Prairie View A&M parking garages. All Residents will be given an opportunity to sign up for parking at resident orientation; a copy of the parking policy and rules will be provided at that time. Residents who sign up for parking must do so for the entire academic year. Residents who cancel parking during the academic year are not eligible to re-enroll until the following open enrollment period and are not entitled to any refunds. Residents who permit use of their parking card by any other individual(s) or otherwise attempt to circumvent the parking system will lose all parking privileges for the duration of their residency/fellowship.

Parking at LBJ will be provided at no cost to UT Housestaff. However, you will still need to be identified with a UT ID Badge and your vehicle will need to be identified with a decal.

The security office will maintain the decals. When a UT HEALTH Housestaff presents their ID Badge, the appropriate decal will be issued and the badge will be coded with access to the applicable parking lots. Each UT HEALTH Housestaff will be issued a decal based upon their work classification.

Z. HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in an effort to protect patients from unauthorized disclosure of their protected health information. Residents in the Program are charged with knowing the information covered under the Act as well as complying with the rules and regulations. HIPAA violations are prohibited. Each Resident may only utilize patient information within the guidelines of the Act.

AA. DISASTER PREPAREDNESS PLAN

In the event of a natural disaster or emergency, all Residents and Interns rotating on the Internal Medicine Service are required to abide by the terms of the official University of Texas- Houston Internal Medicine Residency Program Disaster Plan.

All residents and interns will be notified that the disaster plan is going into effect via a page and an email by the Internal Medicine Office or the Assistant Chiefs of Service Office (ACS). The page and email will state the time and date that the plan is going into effect. The

disaster plan will remain into effect until notified to the contrary by the Internal Medicine Office or the ACS's.

All essential personnel will be required to remain in their assigned locations. If you feel you cannot stay due to personal or family concerns you need to find coverage for your assigned duty. Your coverage needs to be approved by the Assistant Chiefs of Service prior to your being excused.

Residents and Interns on the service will be excused when the disaster plan takes effect. All subspecialty patients need to be checked out to their respective fellow or attending. Return to work immediately after the disaster plan is no longer in effect.

For residents and interns rotating on essential services, the following plan will be activated:

1. All residents and interns **ON-CALL and PRE-CALL** on the day the disaster plan is activated are required to report to their assigned duties immediately.
2. Residents and interns will rotate working 12 hour shifts until the disaster plan is no longer in effect.
3. For Ward Teams - there will be two Ward Teams on duty at a time in each hospital. Ward teams must divide the patients from ALL ward services equally and round on them on them on a daily basis. The cross-cover and admitting duties will then be divided amongst the two ward teams on duty in 12 hour shifts.
4. Renal Wards at Hermann and LBJ will be covered by the Renal Fellow.
5. The ER at LBJ will be covered by all of the residents and interns scheduled for the day and night shifts on the day the disaster plan is activated. They will rotate duties in 12 hour shifts.
6. CCU/Cardiology at Hermann will function similar to the Ward Teams (see number 3).
7. MICU at Hermann and LBJ will rotate duties in 12 hour shifts.

BB. Conclusion

Each Resident shall review this Policy and Procedure Manual and comply with all provisions. Should a Resident have any questions about this Manual, please contact the Program Director immediately. Each Resident is presumed to have read and understood this Policy and Procedure manual, in conjunction with the GME Handbook, unless he/she schedules a meeting with the Program Director to discuss any questions or concerns.